AMENDED IN SENATE JUNE 27, 2002

AMENDED IN SENATE JUNE 12, 2002

AMENDED IN ASSEMBLY MAY 1, 2002

AMENDED IN ASSEMBLY APRIL 10, 2002

AMENDED IN ASSEMBLY APRIL 1, 2002

CALIFORNIA LEGISLATURE—2001–02 REGULAR SESSION

ASSEMBLY BILL No. 2085

Introduced by Assembly Member Corbett

February 19, 2002

An act to *amend Sections 1368 and 1368.01 of, and to* add Section 1368.015 to*,* the Health and Safety Code, relating to health care.

LEGISLATIVE COUNSEL'S DIGEST

AB 2085, as amended, Corbett. Health care.

Under existing law, the Knox-Keene Health Care Service Plan Act of 1975, health care service plans are regulated by the Department of Managed Health Care. A violation of the act by a health care service plan is a crime.

Existing law requires a health care service plan to establish and maintain a grievance system approved by the department, under which enrollees and subscribers may submit their grievances to the plan.

This bill would *require a health care service plan to provide a written acknowledgment of the receipt of a grievance within 5 calendar days of receipt unless the grievance is received by telephone, fax, e-mail, or on line and meets specified requirements or unless the grievance is subject*

to expedited review. The bill would require the plan to keep a log recording specified information for certain grievances exempted from the requirement.

This bill would require every health care service plan to maintain a Web site and, effective July 1, 2003, *would* require a health care service plan ~~with a Web site~~ to allow subscribers and enrollees to submit grievances to the plan online through its Web site. The bill would provide guidelines detailing the specific requirements for the online grievance submission process, including providing access to the department's Web site. The bill would exempt from the requirements, until January 1, 2004, health plans that utilize a hardware system that does not have the minimum system requirements to support the software necessary to meet those requirements.

Because a violation of this bill's requirements regarding online grievances by a subscriber or enrollee would be a crime, ~~this~~ *the* bill would impose a state-mandated local program by creating a new crime.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

The people of the State of California do enact as follows:

SECTION 1. *Section 1368 of the Health and Safety Code is amended to read:*

1368. (a) Every plan shall do all of the following:

(1) Establish and maintain a grievance system approved by the department under which enrollees may submit their grievances to the plan. Each system shall provide reasonable procedures in accordance with department regulations that shall ensure adequate consideration of enrollee grievances and rectification when appropriate.

(2) Inform its subscribers and enrollees upon enrollment in the plan and annually thereafter of the procedure for processing and resolving grievances. The information shall include the location and telephone number where grievances may be submitted.

(3) Provide forms for grievances to be given to subscribers and enrollees who wish to register written grievances. The forms used by plans licensed pursuant to Section 1353 shall be approved by the director in advance as to format.

(4) *(A) Provide for a written acknowledgment within five calendar days of the receipt of a grievance, except as noted in subparagraph (B). The acknowledgment shall advise the complainant of the following:*

(i) That the grievance has been received.

(ii) The date of receipt.

(iii) The name of the plan representative and the telephone number and address of the plan representative who may be contacted about the grievance.

(B) Grievances received by telephone, by facsimile, by e-mail, or on line through the plan's Web site pursuant to Section 1368.015, that are not coverage disputes, disputed health care services involving medical necessity, or experimental or investigational treatment and that are resolved by the next business day following receipt are exempt from the requirements of subparagraph (A). The plan shall maintain a log of all these grievances. The log shall be periodically reviewed by the plan and shall include the following information for each complaint:

(i) The date of the call.

(ii) The name of the complainant.

(iii) The complainant's member identification number.

(iv) The nature of the grievance.

(v) The nature of the resolution.

(vi) The name of the plan representative who took the call and resolved the grievance.

(5) Provide subscribers and enrollees with written responses to grievances, with a clear and concise explanation of the reasons for the plan's response. For grievances involving the delay, denial, or modification of health care services, the plan response shall describe the criteria used and the clinical reasons for its decision, including all criteria and clinical reasons related to medical necessity. If a plan, or one of its contracting providers, issues a decision delaying, denying, or modifying health care services based in whole or in part on a finding that the proposed health care services are not a covered benefit under the contract that applies

to the enrollee, the decision shall clearly specify the provisions in the contract that exclude that coverage.

~~(5)~~

(6) Keep in its files all copies of grievances, and the responses thereto, for a period of five years.

(b) (1) (A) After either completing the grievance process described in subdivision (a), or participating in the process for at least 30 days, a subscriber or enrollee may submit the grievance to the department for review. In any case determined by the department to be a case involving an imminent and serious threat to the health of the patient, including, but not limited to, severe pain, the potential loss of life, limb, or major bodily function, or in any other case where the department determines that an earlier review is warranted, a subscriber or enrollee shall not be required to complete the grievance process or *to* participate in the process for at least 30 days before submitting a grievance to the department for review.

(B) A grievance may be submitted to the department for review and resolution prior to any arbitration.

(C) Notwithstanding subparagraphs (A) and (B), the department may refer any grievance that does not pertain to compliance with this chapter to the State Department of Health Services, the California Department of Aging, the federal Health Care Financing Administration, or any other appropriate governmental entity for investigation and resolution.

(2) If the subscriber or enrollee is a minor, or is incompetent or incapacitated, the parent, guardian, conservator, relative, or other designee of the subscriber or enrollee, as appropriate, may submit the grievance to the department as the agent of the subscriber or enrollee. Further, a provider may join with, or otherwise assist, a subscriber or enrollee, or the agent, to submit the grievance to the department. In addition, following submission of the grievance to the department, the subscriber or enrollee, or the agent, may authorize the provider to assist, including advocating on behalf of the subscriber or enrollee. For purposes of this section, a ''relative'' includes the parent, stepparent, spouse, adult son or daughter, grandparent, brother, sister, uncle, or aunt of the subscriber or enrollee.

(3) The department shall review the written documents submitted with the subscriber's or the enrollee's request for

review, or submitted by the agent on behalf of the subscriber or enrollee. The department may ask for additional information, and may hold an informal meeting with the involved parties, including providers who have joined in submitting the grievance or who are otherwise assisting or advocating on behalf of the subscriber or enrollee. If after reviewing the record, the department concludes that the grievance, in whole or in part, is eligible for review under the independent medical review system established pursuant to Article 5.55 (commencing with Section 1374.30), the department shall immediately notify the subscriber or enrollee, or agent, of that option and shall, if requested orally or in writing, assist the subscriber or enrollee in participating in the independent medical review system.

(4) If after reviewing the record of a grievance, the department concludes that a health care service eligible for coverage and payment under a health care service plan contract has been delayed, denied, or modified by a plan, or by one of its contracting providers, in whole or in part due to a determination that the service is not medically necessary, and that determination was not communicated to the enrollee in writing along with a notice of the enrollee's potential right to participate in the independent medical review system, as required by this chapter, the director shall, by order, assess administrative penalties. A proceeding for the issuance of an order assessing administrative penalties shall be subject to appropriate notice of, and the opportunity for, a hearing with regard to the person affected in accordance with Section 1397. The administrative penalties shall not be deemed an exclusive remedy available to the director. These penalties shall be paid to the State Managed Care Fund.

(5) The department shall send a written notice of the final disposition of the grievance, and the reasons therefor, to the subscriber or enrollee, the agent, to any provider that has joined with or is otherwise assisting the subscriber or enrollee, and to the plan, within 30 calendar days of receipt of the request for review unless the director, in his or her discretion, determines that additional time is reasonably necessary to fully and fairly evaluate the relevant grievance. In any case not eligible for the independent medical review system established pursuant to Article 5.55 (commencing with Section 1374.30), the department's written notice shall include, at a minimum, the following:

(A) A summary of its findings and the reasons why the department found the plan to be, or not to be, in compliance with any applicable laws, regulations, or orders of the director.

(B) A discussion of the department's contact with any medical provider, or any other independent expert relied on by the department, along with a summary of the views and qualifications of that provider or expert.

(C) If the enrollee's grievance is sustained in whole or part, information about any corrective action taken.

(6) In any department review of a grievance involving a disputed health care service, as defined in subdivision (b) of Section 1374.30, that is not eligible for the independent medical review system established pursuant to Article 5.55 (commencing with Section 1374.30), in which the department finds that the plan has delayed, denied, or modified health care services that are medically necessary, based on the specific medical circumstances of the enrollee, and those services are a covered benefit under the terms and conditions of the health care service plan contract, the department's written notice shall *do* either *of the following*: ~~(A) order~~

(A) Order the plan to promptly offer and provide those health care services to the enrollee~~, or (B) order~~.

(B) Order the plan to promptly reimburse the enrollee for any reasonable costs associated with urgent care or emergency services, or other extraordinary and compelling health care services, when the department finds that the enrollee's decision to secure those services outside of the plan network was reasonable under the circumstances. ~~The~~

The department's order shall be binding on the plan.

(7) Distribution of the written notice shall not be deemed a waiver of any exemption or privilege under existing law, including, but not limited to, Section 6254.5 of the Government Code, for any information in connection with and including the written notice, nor shall any person employed or in any way retained by the department be required to testify as to that information or notice.

(8) The director shall establish and maintain a system of aging of grievances that are pending and unresolved for 30 days or more~~,~~ that shall include a brief explanation of the reasons each grievance is pending and unresolved for 30 days or more.

(9) A subscriber or enrollee, or the agent acting on behalf of a subscriber or enrollee, may also request voluntary mediation with the plan prior to exercising the right to submit a grievance to the department. The use of mediation services shall not preclude the right to submit a grievance to the department upon completion of mediation. In order to initiate mediation, the subscriber or enrollee, or the agent acting on behalf of the subscriber or enrollee, and the plan shall voluntarily agree to mediation. Expenses for mediation shall be borne equally by both sides. The department shall have no administrative or enforcement responsibilities in connection with the voluntary mediation process authorized by this paragraph.

(c) The plan's grievance system shall include a system of aging of grievances that are pending and unresolved for 30 days or more. The plan shall provide a quarterly report to the director of grievances pending and unresolved for 30 or more days with separate categories of grievances for Medicare enrollees and Medi-Cal enrollees. The plan shall include with the report a brief explanation of the reasons each grievance is pending and unresolved for 30 days or more. The plan may include the following statement in the quarterly report that is made available to the public by the director:

> ''Under Medicare and Medi-Cal law, Medicare enrollees and Medi-Cal enrollees each have separate avenues of appeal that are not available to other enrollees. Therefore, grievances pending and unresolved may reflect enrollees pursuing their Medicare or Medi-Cal appeal rights.''

If requested by a plan, the director shall include this statement in a written report made available to the public and prepared by the director that describes or compares grievances that are pending and unresolved with the plan for 30 days or more. Additionally, the director shall, if requested by a plan, append to that written report a brief explanation, provided in writing by the plan, of the reasons why grievances described in that written report are pending and unresolved for 30 days or more. The director shall not be required to include a statement or append a brief explanation to a written report that the director is required to prepare under this chapter, including Sections 1380 and 1397.5.

(d) Subject to subparagraph (C) of paragraph (1) of subdivision (b), the grievance or resolution procedures authorized by this section shall be in addition to any other procedures that may be available to any person, and failure to pursue, exhaust, or engage in the procedures described in this section shall not preclude the use of any other remedy provided by law.

(e) Nothing in this section shall be construed to allow the submission to the department of any provider grievance under this section. However, as part of a provider's duty to advocate for medically appropriate health care for his or her patients pursuant to Sections 510 and 2056 of the Business and Professions Code, nothing in this subdivision shall be construed to prohibit a provider from contacting and informing the department about any concerns he or she has regarding compliance with or enforcement of this chapter.

SEC. 2. Section 1368.01 of the Health and Safety Code is amended to read:

1368.01. (a) The grievance system shall require the plan to resolve grievances within 30 days.

(b) The grievance system shall include a requirement for expedited plan review of grievances for cases involving an imminent and serious threat to the health of the patient, including, but not limited to, severe pain, potential loss of life, limb, or major bodily function. When the plan has notice of a case requiring expedited review, the grievance system shall require the plan to immediately inform enrollees and subscribers in writing of their right to notify the department of the grievance. The grievance system shall also require the plan to provide enrollees, subscribers, and the department with a written statement on the disposition or pending status of the grievance no later than three days from receipt of the grievance. *Paragraph (4) of subdivision (a) of Section 1368 shall not apply to grievances handled pursuant to this section.*

SEC. 3. Section 1368.015 is added to the Health and Safety Code, to read:

1368.015. (a) Effective July 1, 2003, every plan with a Web site shall provide an online form through its Web site that subscribers or enrollees can use to file with the plan a grievance, as described in Section 1368, online.

(b) The Web site shall have an easily accessible online grievance submission procedure that shall be accessible through a hyperlink on the Web site's home page or member services portal clearly identified as ''GRIEVANCE FORM.'' All information submitted through this process shall be processed through a secure server.

(c) The online grievance submission process shall *be* approved by the Department of Managed Health Care and shall meet the following requirements:

(1) It shall utilize ~~be~~ an online grievance form in HTML format that allows the user to enter required information directly into the form.

(2) It shall allow the subscriber or enrollee to preview ~~of~~ the grievance that will be submitted, including the opportunity to edit the form prior to submittal.

(3) It shall include a current hyperlink to the California Department of Managed Health Care Web site, and shall include a statement in a legible font that is clearly distinguishable from other content on the page and is in a legible size and type, containing the following language:

''The California Department of Managed Health Care *(Department)* is responsible for regulating ~~health care service plans~~ *HMOs*. If you have a grievance against your ~~health plan~~ *HMO*, you should first telephone your ~~plan~~ *HMO* at (~~plan's~~ *HMO's* telephone number) and use the ~~plan's~~ *HMO's* grievance process before contacting the ~~department~~ *Department*. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your ~~plan~~ *HMO*, or a grievance that has remained unresolved for more than 30 days, you may call the ~~department~~ *Department* for assistance. The ~~department's~~ *Department's* Internet Web site (http://www.dmhc.ca.gov) has complaint forms and instructions online. The ~~department~~ *Department* also has a toll-free telephone number (1-888-HMO-2219) and the hearing and speech impaired may use the ~~department's~~ *Department's* TDD line (1-877-688-9891) to contact the ~~department~~ *Department*.''

The plan shall update the URL, hyperlink, and telephone numbers in this statement as necessary.

~~(4) It shall provide the subscriber or enrollee a referral number that may be used to obtain information from the plan regarding the status of the grievance.~~

~~(d) Upon receipt of an online grievance, the plan shall provide a confirmation receipt to the enrollee or subscriber via United States mail, via e-mail if authorized by the enrollee or subscriber, or via a secured, private communication on the plan member's individual member services portal.~~

~~(e)~~

(d) A plan that utilizes a hardware system that does not have the minimum system requirements to support the software necessary to meet the requirements of this section shall be exempt from these requirements until January 1, 2004.

~~(f)~~

(e) For purposes of this section, the following terms shall have the following meanings:

(1) ''Homepage'' means the first page or welcome page of a Web site that serves as a starting point for navigation of the Web site.

(2) ''HTML'' means Hypertext Markup Language, the authoring language used to create documents on the World Wide Web, which defines the structure and layout of a Web document.

(3) ''Hyperlink'' means a special HTML code that allows text or graphics to serve as a link that, when clicked on, takes a user to another place in the same document, to another document, or to another Web site or Web page.

(4) ''Member services portal'' means the first page or welcome page of a Web site that can be reached directly by the Web site's homepage and that serves as a starting point for a navigation of member services available on the Web site.

(5) ''Secure server'' means an Internet connection to a Web site that encrypts and decrypts transmissions, protecting them against third-party tampering and allowing for the secure transfer of data.

(6) ''URL'' or ''Uniform Resource Locator'' means the address of a Web site or the location of a resource on the World Wide Web that allows a browser to locate and retrieve the Web site or the resource.

(7) ''Web site'' means a site or location on the World Wide Web.

~~SEC. 2.~~

(f) Every health care service plan shall maintain a Web site.

SEC. 4. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

O